PRINTED: 03/22/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

NVS3923ADA A. BUILDING B. WING 12/21/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	10				
WESTCARE NEVADA WOMEN & CHILDRENS CAMPU 5659 DUNCAN DRIVE LAS VEGAS, NV 89130	UNCAN DRIVE				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM-	(X5) COMPLETE DATE				
D 000 Initial Comment D 000					
The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. This Statement of Deficiencies was generated as a result of the Complaint Investigation conducted on your facility on 11/9/10 and completed on 12/21/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 130 residential program beds for the treatment of abuse of alcohol and drugs. Complaint #NV00026820 was not substantiated. The facility was found to not be responsible for and reacted appropriately to a cluster of viral meningitis cases in the facility through document review, staff interview and observations. Complaint #NV00026820 was initiated by the Bureau of Healthcare Quality and Compliance on 11/9/10. The investigation into this cluster of four viral meningitis cases included: - Review of the facility's infection control policies, staff meeting minutes, and cleaning charts and schedules. - Interviews were conducted with the Deputy Administrator, Program Director, Supervisors and one of the infected clients					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 03/22/2011 FORM APPROVED

Bureau of Health Care Quality and Compliance

NAME OF PROVIDER OR SUPPLIER WESTCARE NEVADA WOMEN & CHILDRENS CAMPU (X4) ID PREFIX TAG CANDID PREFIX TAG CONTINUED FOR PROVIDER OR SUPPLIER OCCUPANT TAG CANDID PREFIX TAG CANDID PREFIX TAG CONTINUED FOR PAGE OF THE APPROPRIATE DATE OF TH	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING					
NAME OF PROVIDER OR SUPPLIER WESTCARE NEVADA WOMEN & CHILDRENS CAMPU (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 000 Continued From page 1 - Observations were made of public hallways, cafeteria, common meeting rooms, public restrooms, baby changing stations and all infected client's bedrooms and bathrooms for adherence to the Centers for Disease Control STREET ADDRESS, CITY, STATE, ZIP CODE 5659 DUNCAN DRIVE LAS VEGAS, NV 89130 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE COMPLETE DATE D 000 O 000										
WESTCARE NEVADA WOMEN & CHILDRENS CAMPU (X4) ID PREFIX TAG D 000 Continued From page 1 - Observations were made of public hallways, cafeteria, common meeting rooms, public restrooms, baby changing stations and all infected client's bedrooms and bathrooms for adherence to the Centers for Disease Control SUMMARY STATEMENT OF DEFICIENCIES LAS VEGAS, NV 89130 PROVIDER'S PLAN OF CORRECTION (X5) PREFIX TAG CEACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OD 000 OD 000 OD 000 TO 0	•									
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTION SHOULD BE DEFICIENCY) D 000 Continued From page 1 - Observations were made of public hallways, cafeteria, common meeting rooms, public restrooms, baby changing stations and all infected client's bedrooms and bathrooms for adherence to the Centers for Disease Control LAS VEGAS, NV 89130 PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD										
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 000 Continued From page 1 Observations were made of public hallways, cafeteria, common meeting rooms, public restrooms, baby changing stations and all infected client's bedrooms and bathrooms for adherence to the Centers for Disease Control PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE D 000 Continued From page 1 D 000 D 000 D 000	WESTCADE NEVADA WOMEN 9 CUII DDENS CAMDII I									
- Observations were made of public hallways, cafeteria, common meeting rooms, public restrooms, baby changing stations and all infected client's bedrooms and bathrooms for adherence to the Centers for Disease Control	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	CTION SHOULD BE COMPLETE DATE DATE			
cafeteria, common meeting rooms, public restrooms, baby changing stations and all infected client's bedrooms and bathrooms for adherence to the Centers for Disease Control	D 000	Continued From page 1			D 000					
		- Observations were made of public hallways, cafeteria, common meeting rooms, public restrooms, baby changing stations and all infected client's bedrooms and bathrooms for adherence to the Centers for Disease Control		ır						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.